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INTENSIVE CASE MANAGEMENT:

State-Wide Summary

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This report summarizes the major findings from the recent evaluation of the intensive case management program. The focus is on what is occurring on a state-wide basis, rather than with any particular region or intensive case management site.

An overview of the intensive case management program in Montana is included. We included exemplary practices encountered, as well as concerns that were raised by the evaluation. It is hoped that this will lead to improved intensive case management services for those with a severe disabling mental illness.

The tables in Appendix B were included for those who desire more detailed information about intensive case management consumers state-wide. The tables in Appendix C were included to provide the opportunity for CMHC regions and intensive case management sites to compare the consumers they are serving with other CMHC regions and intensive case management sites in the state. These tables are meant to be descriptive and not an evaluation of the quality of the intensive case management services being offered in any CMHC region or at any intensive case management site.

If you have any questions about the intensive case management program, contact the Mental Health Bureau.

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INTRODUCTION

This report provides an overview of the Intensive Case Management program in Montana. Intensive case management services are being funded under the Mental Health Services for the Homeless (MHSH) Block Grant Program (PL. 100-77). These services are targeted toward adults who have a severe and disabling mental illness and who are homeless or subject to a significant probability of becoming homeless. Persons not receiving mental health services or having only limited connection with the public mental health system are a priority target population. Persons involved in the mental health system are more likely to be receiving assistance in obtaining the basic services needed to maintain community tenure, with many of the case management functions being provided by aftercare staff in day treatment, transitional living, and other programs.

Priority was also given individuals who are dually diagnosed either due to a developmental disability or substance abuse.

Purpose of the Evaluation

This evaluation has multiple objectives. The primary objective is to determine the degree of contract compliance. The community mental health centers have been notified of any problems that needed to be corrected for compliance with the Intensive Case Management Contract.

The second objective is to assess the degree to which the Intensive Case Management programs were meeting the purposes of PL 100-77---the use of public resources and programs (including public mental health services) in a more coordinated manner to meet the critically urgent needs of the homeless mentally ill of the state. Of concern is the degree to which funded intensive case management services targeted mentally ill individuals who were homeless or at significant risk of becoming homeless, rather than supporting existing services and clients.

The last objective was to assess the degree to which the underlying values and philosophy of the intensive case management program were being implemented. The report will describe some exemplary examples of the implementation of the underlying philosophy. This should provide ideas on how intensive case management services can be altered to be of greater benefit to the consumers of the service. The analysis of the implementation of the underlying values and the degree the intensive case management program targets homeless mentally ill will be a basis for change in future intensive case management contracts.

Purpose of Report

This report identifies the current state of intensive case management services in Montana. It is not a forum outlining the compliance problems identified in any one region or at any one case management site. It provides an overview of the findings of the separate evaluations. Exemplary efforts to serve severely mentally disabled homeless persons are highlighted in the report. Included is an overview of the shortcomings of the system

from the perspective of the evaluators. Data indicating who is being served by the intensive case management programs are also presented.

OVERVIEW OF THE INTENSIVE CASE MANAGEMENT PROGRAM

Funding Source

Funding for intensive case management comes from the State Block Grant for Services to Homeless Individuals to Chronically Mentally Ill (PL. 100-77, Title VI, Subtitle B, Section 611)[1]. This law authorized a new block grant program for states. The funds were to be used in developing and providing comprehensive community services for homeless individuals who have a severe and disabling mental illness. To receive funds, the state had to ensure that the money would be used to develop local service programs (either public or private non-profit) which would provide the following services to seriously mentally ill who are homeless or who are subject to a significant probability of becoming homeless (Part C, Section 524).

1. Outreach services including crisis intervention, and general assessment of needs.

2. Community mental health services including diagnostic services, crisis intervention, and habilitation and rehabilitation services.

3. Referral, as appropriate, for medical and primary health services and for substance abuse services.

4. Training to individuals who provide services to homeless people, including those who work in shelters, mental health clinics, and other sites where homeless people receive services. Training must include how to: (1) identify individuals who have a severe and persistent mental illness; (2) refer to available services, such as job training, literacy education, community health centers, community mental health centers, and substance abuse treatment programs; and (3) identify programs that provide benefits to homeless individuals and refer individuals to these programs.

5. Case Management for homeless mentally ill individuals, including (1) preparing a plan for the provision of mental health services to the homeless individual and reviewing the plan at least once every three months; (2) providing assistance in obtaining and coordinating social and maintenance services for the individual, including rehabilitation services, prevocational and vocational services, and housing services; (3) providing assistance to the individual in obtaining income support services, housing assistance, food stamps, and Supplemental Security Income benefits; (4) referring the individual for such other services as may be appropriate; and (5) providing representative payee services if the individual is receiving Supplemental Security

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[1]. This public law is referred to as the "Stewart B. McKinney Homeless Assistance Act".

Income benefits and provided that the applicant is designated by the Social Security Administration to provide such services.

6. Residential Services, including supportive and supervisory services to previously homeless individuals who are placed in a residential setting, except if the individual is living in a project supported by federal Transitional Housing Demonstration funds or Supportive Housing Demonstration funds program.

Services provided through the MHSH Block Grant must be consistent with the state mental health plan required by the State Comprehensive Mental Health Services Plan Act enacted in 1986 (PL 99-660). As a result of PL 100-77, the State Planning Council (established in accordance with the requirements of PL 99-660) is given the additional responsibility of assuring the integration of services for homeless mentally ill persons into the state mental health service system. [Part 2, Section 526(c)].

The state received $275,000 in block grant money which was matched with $110,000 state dollars. The total funding of $385,000 was used to hire fifteen (15) full-time intensive case managers to provide services to homeless mentally ill, including case finding, outreach, referral, and training of individuals who provide services to homeless people. The number of intensive case manager FTE's allocated to each CMHC region was based on the region's population. Each region was allowed to split one FTE into two half-time positions, with prior approval of the State Mental Health Bureau. The contract period for services purchased with the federal FY 1988 MHSH Block Grant is August 1, 1988 through June 30, 1989.

Homelessness

The intensive case management program is to serve severely mentally ill individuals who are homeless or at a significant probability of becoming homeless. The definition of homelessness was that of the Stewart B. McKinney Homeless Assistance Act (PL 100-77). This Act includes as homeless:

(1) An individual who lacks a fixed, regular, and adequate nighttime residence; and

(2) an individual who has a primary nighttime residence that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings [Title I, Section 103(a)].

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[1] FTE - Full Time Equivalent Position

No official estimate exists of the number of homeless mentally ill in Montana, either on a statewide basis or for individual communities. The intensive case management program has had mixed results in identifying and engaging homeless mentally ill persons who are truly homeless. Great Falls stands out in serving the homeless mentally ill with 41% of the consumers they had served as of April 15, 1989 being homeless at the time the case was opened.

Table 1 gives the number and percent of homeless mentally ill served by each intensive case management site.

TABLE 1

Number and Per Cent of Consumers who were homeless at the time a case was opened by Program Site as of April 15, 1989.

ICM Site	Total Caseload	Homeless Number	Per Cent
Yellowstone County	77	12	16%
Silver Bow County	25	1	4%
Dawson & Richland Counties	16	2	12%
Cascade County	71	29	41%
Hill County	14	0	0%
Lewis & Clark County	36	11	31%
Flathead County	43	9	21%
Park County	16	2	12%
Custer County	30	1	3%
Missoula County	60	8	13%

Most of the consumers being served by the program are at significant risk of becoming homeless. There was initial confusion in identifying persons at risk of becoming homeless. When the program was initiated an operational definition of at risk of becoming homeless had not been developed. Because of the case manager uncertainty about this the Department of Institutions has developed an operational definition for being 'at risk of becoming homeless.' The Department plans to continue to refine this definition during the second year of the project. The operational definition for 'at risk of becoming homeless' is in Appendix A.

Significant progress is being made in addressing the need of the homeless mentally ill in the communities served by the intensive case management programs. Case managers in Livingston and Kalispell have developed informal networks to identify and respond to the needs of the homeless. Neither of these communities has a shelter, consequently they have had to develop other community contacts to identify homeless in the community. In Livingston 12% and in Kalispell 21% of the consumers served were homeless. In Butte and Helena, the intensive case management programs have taken the lead in establishing a community coalition to identify and

address the needs of homeless persons in the respective communities. In both communities this coalition development has begun only recently. Missoula and Great Falls have concentrated on developing relationships with the agencies which come into contact with the homeless in the community. This included not only the more traditional agencies such as the shelter, but also "informal" providers, such as the library and police, who come into contact with homeless mentally ill individuals. The focus has been on educating individuals in recognizing the potential signs of mental illness. Further, in Great Falls the case managers have made educational presentation to community organizations and groups on the homelessness problem in the community. This has resulted in the program being able to obtain donations so that they have their own supply of frequently needed and difficult to obtain items. The intensive case management program in Billings and Missoula will have representatives on homeless coalitions which are being developed in these communities.

Value Base

The philosophy and values underlying the intensive case management program were delineated in the intensive case management contract. This report expands upon this by reformulating and refining the values which guide the program.

The value base that underlies a program provides the direction for program implementation and therefore is extremely important. Values lead to assumptions about people and the social context in which they live, and serve as a basis for the operating principles of the intensive case management program. Is the consumer a passive recipient of services in which his/her needs are defined "in ways that correspond to the system outputs available to clients, or more simply, aggregating them [available services] into a priority treatment package" (Rose, ND, 10)? Or is the consumer an active participant in defining his/her needs and how to best achieve those needs? Is the focus on client pathology and control of that pathology? Or is the focus on consumer strengths and how to develop and build on those strengths?

The values that serve as the premises for the intensive case management program are as follows:

Consumers need to be understood as persons living in a social context. The community (social context) in which a person lives can be a resource for growth and movement.

People can continue to learn, grow, and change when provided with the necessary material, social, and emotional supports to succeed.

Growth and movement occur in the context of supportive relationships characterized by clarity of goals, continuity between goals, purposes and actions, and sustained movement toward each person's optimal capacity for autonomy and community living.

Consumers are seen as unique individuals whose needs vary over time, in intensity, and in scope.

Diagnosis and previous formal system status do not determine future capacity, capacity to grow and develop, or capacity to live positively in community settings, nor do they restrict the resources, relationships, and potential for anyone.

These values lead to assumptions about people who are long term psychiatrically disabled, the social context in which they live, the interaction between the people and their social situation, and about the nature of case management activities on their behalf. All human beings are entitled to be treated with dignity and respect. The basis for the development of the case manager's relationship and goal organizing practices with consumers is this dignity and presumed capacity to grow and change, rather than diagnostic classifications. The focus is on consumer strengths, not pathology. Consumer self-determination is maximized, with consumer needs defining agency and resource relevance, not the opposite. The involvement of the consumer in defining goals is maximized and focuses on needed material, social, relationship, emotional, and skill based supports regardless of the present levels of system responsiveness. The ongoing process of case management is based on the changing nature of the consumer's individual needs.

Operational Principles

The value base provides a number of operational principles which serve to guide case management activities. These principles are as follows:

1. The case manager's focus is on identifying and reinforcing an individual's strengths.

2. Interventions are based on the principle of client self-determination, with consumer goals, needs, and priorities of central concern. The consumer is viewed as having the ability to make choices and decisions and must be involved in every step of the case management process. The facilitation of this involvement is dependent on viewing the consumer as the director of his/her intervention. Consumer identified issues are the focus of the case management activities and the consumer is encouraged to do as much as he/she can with as little help as is necessary. The success of this process is ensured by viewing the consumer as an individual with both strengths and needs, able to make decisions and participate in his/her life planning. Consumer empowerment is achieved through the accomplishment of short term goals.

3. The case manager-consumer relationship is primary and essential to the case management activities. This relationship conveys to the consumer a sense of hope and a means in which this hope can be achieved. The primary goal of the relationship is consumer empowerment through the development of a warm human helping experience which promotes growth and change; the process of learning to know and act in one's own interest.

4. Assertive outreach is the preferred mode of intervention. Work is performed in the consumer's environment where there is an opportunity to operationalize the intent of the case management activities within the consumer's social context. Out of office contacts are the rule rather than the exception. By entering the consumer's environment, the case manager can gain a better understanding of the consumer's life needs and create opportunities to teach and practice those skills necessary for survival in the community. This perspective maximizes the consumers engaging in responsible, independent community living and minimizes the potential of their dropping out of treatment. Assertive outreach reinforces empowerment and normalization and increases the likelihood of independence from client status type of involvement.

5. Resource acquisition activities are used to acquire environmental resources needed to live positively in the community. The focus for acquisition goes beyond traditional mental health services and is on those resources which will reinforce the persons' capacity to grow and develop stable lives as community participants. Resource acquisition involves the process of decreasing dependence upon formal service providers, increasing independence from client status types of involvement and their respective replacement by informal and natural support networks. The development of support networks (e.g., consumer operated self help groups) may be a necessary part of this activity.

6. All people have the ability to learn, grow and change. The case management process is driven by the belief that people have the capacity for growth and change no matter what their condition (physical and/or emotional) or the circumstances which surround their life.

> As Reynolds (1935, p. 236) stated, "if we really believe that life is for growth then we shall use no methods that in themselves hamper the growth of the human spirit." Too often, professionals working with long term psychiatrically disabled limit expectations, do not actively engage with the person or believe that change is possible. The case manager has a responsibility to teach skills, practice these skills with the consumer, and create opportunities for the consumer to use the skills. The case manager support and encourages the consumer to do as much as they can with as little help as is necessary. (Modrcin, Rapp, & Chamberlain, 1985, p. 71)

7. The community is viewed as a resource and not as an obstacle. That resources are available in the community is implicit in this conceptualization and it is the case manager's responsibility to locate, mobilize, or influence these resources to respond to the

consumer's needs. This is a creative process and requires that the case manager be assertive with key actors who control community resources, create community collaborators to support the consumer's effort at community living, and work to develop natural support networks. This implies that the case manager be available to community collaborators to help with emergencies, problems, and to provide ongoing support and praise.

8. Advocacy is a central activity in developing and ensuring consumer empowerment. Advocacy involves not only ensuring access to appropriate resources and services for individual consumers, but the identification of system deficits that obstruct consumer capacity to grow and develop stable lives as community participants. According to Rose (ND), advocacy

> assumes that the objective parameters for providing the material base for sustained social life are not readily available, are frequently denied in relation to their urgency and necessity by providers of partial services (health care and mental health care organizations, for example, rarely intervene in generic or community-wide housing crises), yet are vital to clients' capacities to survive and develop as well as to case managers' capacities to function effectively (p. 13-14)

Consumer empowerment is not possible if the case manager is restrained in functioning as the consumer's advocate.

Intensive Case Management Program Sites

The Intensive Case Management contract provides for the funding of 15 FTE (full time equivalent) case manager positions in the five mental health regions. Intensive case management services are also provided by three case managers funded by the Long Term Community Support Project. The caseloads for these three case managers are included in the overall analysis for the intensive case management program.

Eastern Montana Community Mental Health Center
(Region I)

Eastern Montana Community Mental Health Center (EMCMHC) is a private, nonprofit regional community health center serving 17 counties in eastern Montana. EMCMHC operates full-time programs in eight communities and staff travel to other communities to provide part-time services. EMCMHC is receiving $51,333 ($36,666 federal; $14,667 state) for 2 FTE intensive case managers to provide services under the MHSH Block Grant program. One full-time case manager and one half-time case manager are located in Miles City and one half-time case manager divides her time between Glendive and Sidney. The full-time case manager works out of the CMHC clinic office. The half-time case manager in Miles City works out of Clark Street Inn and primarily

provides intensive case management services to Clark Street Inn residents. Supervision for all the case managers is the responsibility of the Clinical Director in Miles City. There is a single advisory committee for the intensive case management programs in the region. This committee includes a representative from the Miles City AMI group, and representatives from Glendive and Sidney.

Golden Triangle Community Mental Health Center (Region II)

Golden Triangle Community Mental Health Center (GTCMHC) serves nine counties in north central Montana. GTCMHC is a private, nonprofit regional community mental health center which operates programs in eight communities. GTCMHC is receiving $77,000 ($55,000 federal; $22,000 state) to provide intensive case management under the MHSH Block Grant program. GTCMHC has four FTE case manager positions; three hired under the Intensive Case Management contract (MHSH Block Grant program) and one hired under the Long Term Community Support contract. Three full-time and one half-time case managers are located in Great Falls and a half-time is located in Havre. The intensive case management unit in Great Falls is located at the New Directions Center with supervision provided by a psychiatric nurse. Although located in the New Directions Center, the program has a separate identity from all other aftercare programs. The half-time case manager in Havre works out of the CMHC clinic office. The Havre case manager is supervised by the director of the day treatment program. The case manager also works half-time in this day treatment program. The intensive case management program is structured in a manner so that it will remain separate from the day treatment program, and includes a specific time that is set aside for supervision related to case management. The case manager helps maintain this separate identity by seeing the case management consumers outside of the CMHC facility. Overall direction for intensive case management in Region II is provided by the Director of Alternative Services for the region. There is one advisory committee for all case management programs in the region with representation from both Great Falls and Havre.

Mental Health Center (Region III)

Mental Health Center (MHC) is a private, nonprofit regional community mental health center serving eleven counties in south central Montana. MHC operates full-time programs in five communities and part-time services in several other towns. MHC is receiving $77,000 ($55,000 federal; $22,000 state) to provide intensive case management under the MHSH Block Grant program. MHC has three FTE case manager positions, all funded by the Intensive Case Management contract. The three case managers are located at the CMHC clinic office in Billings. Supervision and program direction is the responsibility of the Director of Alternative Services. There is an advisory committee composed of consumers, advocates, and a case manager that serves this program.

Mental Health Services, Inc.
(Region IV)

Mental Health Services, Inc. (MHS) is a private, nonprofit regional community mental health center which provides services for a twelve county area in southwestern Montana. MHS operates full-time programs in five communities with staff traveling to other communities to provide part-time services. MHS is receiving $77,000 ($55,000 federal; $22,000 state) to provide intensive case management under the MHSH Block grant program. MHS has three FTE case manager positions. One full-time and one half-time case manager serve the Helena area. These case managers are housed at Montana House, the adult day treatment program. Supervision is the responsibility of the director of the adult day treatment program. A full-time case manager provides intensive case management services in Butte. She is housed at Silver House, the adult day treatment program. Supervision is provided by the director of the day treatment program. A half-time case manager serves the Livingston area. She is housed at Mountain House, the adult day treatment program. There is an advisory committee for each of the case management programs in Region IV. This reflects the differences in the needs of the communities being served by the programs. The advisory committee for the Helena intensive case management program is a subcommittee of the Montana House advisory committee and has representation from the Helena AMI group. Butte and Livingston each have advisory committees made up of consumers, advocates, and community representatives.

Western Montana Community Mental Health Center
(Region V)

Western Montana Community Mental Health Center (WMCMHC) serves the western-most seven counties of Montana. This private, nonprofit community mental health center operates full-time programs in six communities and a part-time office in one community. WMCMHC is receiving $102,667 ($73,334 federal; $29,333 state) to provide intensive case management under the MHSH Block Grant program. WMCMHC has six FTE case manager positions. Four of these are funded by the Intensive Case Management contract (MHSH Block Grant program) and two are funded by the Long Term Community Support contract. Four full-time case managers serve the Missoula area. They are housed at River House, the adult day treatment program. Administrative coordination of case management activities is the responsibility of one of the case managers. Clinical supervision is provided by a MSW on staff at River House. Overall program direction is the responsibility of the Director of Aftercare Programs. Two case managers serve Kalispell. They are located at Lamplighter House, the adult day treatment program. Supervision is provided by the Director of River House. Each of these communities has their own case management advisory committee, reflecting differences in the needs in each of the communities. Representatives of the local AMI groups serve on each of these advisory committees.

Program Intent and Intensive Case Management Practice

The compliance with both the letter and intent of the intensive case management contract was mixed. However, overall the evaluators felt substantial efforts were being made to meet the needs of homeless mentally

ill persons in the state. At many intensive case management sites, there has been a conscious effort made to implement a consumer directed case management program.

Contract deficiencies encountered during the evaluation are presented below. These are objective standards which are easily measured. At a later point in this report, we discuss some concerns about the implementation of the intent of the intensive case management program. These concerns are more related to the manner in which the philosophy of the program has been implemented.

Common Contract Deficiencies

In terms of specific problems which constituted non-compliance with the contract, the evaluators identified two areas of deficiency which were commonly encountered during the statewide review.

The first, and most commonly found deficiency related to a failure of the case file to clearly document the homeless status of the consumer. Frequently, the "Opening Evaluation Data Sheet" in the consumer files did not demonstrate that the individual was either homeless or at risk of becoming homeless. Consequently, these consumers were technically ineligible for the intensive case management program.

However, the evaluators determined that the primary difficulty was one of documentation, rather than inappropriate admissions to the program. Further, the reason for this documentation problem stemmed largely from confusion over the vagueness of the definition of "at risk of becoming homeless." As a result, specific criteria for determining homeless status have been developed and will be disseminated to the programs statewide.

The second major problem area identified by the evaluators was in regard to the development and maintenance of consumer service plans. Frequently identified deviations from contract requirements were:

- Missing signatures of the consumer and/or case manager on the plan.
- Failure to review and update the plan, as required.
- Plans which were incomplete or missing entirely.
- Plans which were vague, overly general, and/or did not reflect all services being provided.

While the evaluators reviewed many excellent service plans, the statewide picture suggests that this is an area for program consideration and review. This issue is further addressed elsewhere in this report.

EXEMPLARY INTENSIVE CASE MANAGEMENT PROGRAM PRACTICES

The evaluators identified several practices of case management sites that were effective in meeting the objectives of the program. These are described here to provide ideas for other intensive case management programs in the state.

One program was very effective at serving the homeless mentally ill in the community. Initially, the case managers and their supervisor visited all the human service agencies in the community which potentially could come into contact with the homeless. This first visit was to explain the intensive case management program. After the initial visits the case managers were each assigned agencies which they were responsible for contacting weekly. By making in-person visits to these human service agencies the program was able to develop and maintain relationships with the agencies and continually educate agency personnel about mental illness and homelessness. The case managers respond to all referrals from these community agencies. This has not only helped maintain the relationship between the intensive case management program and the agency, but provides an opportunity for the case managers to educate staff when the referral does not fit the criteria for intensive case management. The case managers also help staff determine where an individual can be referred for services when the referral is not appropriate for intensive case management services. This same program has provided education to community groups about the intensive case management program and homeless mentally ill persons. These education efforts have made it possible for the intensive case management program to get community groups to help in meeting the needs of the homeless mentally ill in the community.

One program has developed a procedure to ensure that the case manager is the consumer's advocate whenever hospitalization is a possibility. The case manager is the advocate for the consumer throughout the process of hospitalization. This is the case even if the potential need for hospitalization is initially recognized by the case manager. Once the concern is communicated to one of the professional staff, the case manager is responsible for being present to act as advocate.

Another program site has used the advisory board as a means of educating key community members about the program. Along with consumers and family members, they have included the legal aid attorney and a representative form the Social Security office. This has created an environment where very good relationships have developed between the intensive case management program and these services. This has benefited consumers as many of the program referrals come from the advisory board members.

Two programs utilize consumers. One program has hired a consumer as case manager. This person has been able to very rapidly establish relationships with consumers, particularly those who are non-help-seeking. In another program, a consumer who is a member of the advisory board accompanies the case manager on some community visits. This began as a means of allowing the case manager to visit consumers in the community when there was a question of her personal safety involved. However, a secondary benefit has been a positive impact on the case manager's ability to engage difficult-to-reach individuals and more rapidly establish a working relationship with the consumer. Although the consumer who accompanies the case manager does not take an active role in the case management process, his presence seems to have accelerated the case manager's acceptance by many individuals.

The evaluators were pleased to see consumers involved in case management. Evidence indicates that consumers can function effectively as case managers. It is hoped that other programs will explore ways in which consumers can be used as case managers. The evaluators feel that consumers should be compensated for working as case managers and not be expected to do it as a volunteer or as part of a therapeutic plan.

Another program has one case manager working with a group of consumers helping them start a consumer self-help/self-advocacy organization. Once established this will provide a community-based organization that can be helpful in developing social networks.

SYSTEM WIDE CONCERNS IDENTIFIED DURING THE EVALUATIONS

During the course of the statewide review, certain aspects of the overall intensive case management program grew to become matters of concern to the evaluators. These issues, or areas of concern, are addressed below in the hope of stimulating thought and discussion that will lead to further refinement of the intensive case management services in the state. These issues relate more to how the philosophy and value base of the intensive case management program were implemented rather than to specific objective standards such as the contract deficiencies discussed above.

Burnout Potential

Through interviews with each intensive case manager, reviews of the consumer files, and discussion with supervisors and others, the evaluators were able to glimpse the tremendous task faced daily by the case managers.

The evaluators were struck by the energy and dedication exhibited by intensive case managers. To a person, they expressed caring and concern for the consumers they served, and we saw absolutely no indication of hesitancy to exert energy. We did see, however, some people beginning to weary, and we began to wonder what programs, supervisors, and the intensive case managers, themselves, need to do to diminish the likelihood of burnout occurring.

Outreach

The homeless mentally ill, as a population, have been described as heterogeneous, underserved, and having multiple needs. These individuals tend to be low utilizers of service and are often described as "non-compliant", "service resistant", and "difficult-to-serve". As Rog (1988) has indicated:

> Low service utilization among persons who are homeless and mentally ill is a complex and multi-faceted problem. Although it is generally believed to be due, in part, to the behaviors and attitudes of the individuals themselves, there has been increasing recognition of the barriers within the system that create service resistance among members of this population. These barriers include the attitudes, expectations, and behaviors of service providers; the design of service programs and settings; and the operation and configuration of the overall system of care (p.40).

Intensive case management is one approach which has been utilized to enlist consumers in social and mental health service. Other approaches have included outreach programs, drop-in centers, and consumer self-help programs.

The intensive case management program has produced mixed results in engaging non-help-seeking mentally ill adults. At many sites the evaluators found a concerted effort being made to identify and engage this population. One indicator of this is the number of consumers being served by intensive case management who have had no prior contact with the mental health centers. Another indicator was the effort to develop and maintain contact with service providers who come into contact with this population. At one site the case managers had identified a community location where they would frequently come into contact with this population. The case managers made regular visits to this location. Another site has a routine schedule by which the case managers visit service providers on a regular basis. The intensive case managers felt this regular contact increased the likelihood these providers would refer potential consumers to the program. The experience of some of the intensive case management sites indicates that locating and engaging the non-help-seeking population is possible. However, it takes a concerted effort on the part of the intensive case management program to design a process that maximizes this potential.

Is there a need to develop active outreach? Are there a significant number of adults with a severe and disabling mental illness who are not being served by the public mental health system? Determining the number of adults with a severe and disabling mental illness in the state or in a CMHC region is a difficult task. Although several methods exist for estimating the numbers, there is not agreement on which method is the best or most accurate. Service planning and development, at best, is difficult without an estimate of the population in need.

The Department of Institutions estimates that there are 6,072 adults with a severe and disabling mental illness in the state, 10.94 for every 1000 population. This estimate is an average of the estimates derived using the "Quadrant model" and the "DU Logistics model". The quadrant model uses SSI and SSDI data to derive an estimate of the population in need. The DU Logistics method uses indicators developed as a result of research done by Denver University. Both of these approaches are likely to provide a conservative estimate as they are based on a more limited range of diagnoses that the definition of severe and disabling mental illness utilized by the state.

Based on data from the regional community mental health centers, there are 2,175 adults with a severe and disabling mental illness being served. On a state-wide basis, this means that the CMHC's are serving 35.8% of the adults with a severe and disabling mental illness in the state. The number being served by individual CMHC's varies from 28% to 59%. Table 2 gives the estimates of the number of adults with a severe and disabling mental illness being served by each of the CMHC regions. This data is only an estimate, but it suggests that on a state-wide basis 64% of the mentally ill adults are not being served by the community mental health system. This data suggests the importance of outreach activities if the CMHC's are to meet

their obligation to serve this population. Increased outreach activities by the intensive case managers can be a start in this direction.

TABLE 2

Estimates of the Numbers of Adults with a severe and disabling mental illness by Community Mental Health Region and for the State

	CMHC REGION					State
	I	II	III	IV	V	
Method						
Quadrant	570	1,206	1,158	1,560	1,707	6,201
DU Logistics	773	1.096	1.194	1,375	1,505	5,943
Average	572	1,151	1,176	1,468	1,606	6,072
No. Per 1000 Population	10.01	10.50	10.43	10.95	11.40	10.94

Outreach, or engagement, is the process of making and "maintaining contact with a person who for many reasons may not have been able to gain access to traditional service providers in the past" (Axleroad and Toff, 1987, p. 5). The engagement of non-help-seeking and "homeless mentally ill individuals requires a conceptual shift from traditional, clinic-based models" (Rog, 1988, p.14) of service provision. Outreach is a "function which must be incorporated into any comprehensive mental health service system. Outreach services must be flexible, accessible, and non-threatening to clients. Outreach programs must be linked to other community resources, including police, shelters, hospitals, sources of permanent housing, entitlement programs, and rehabilitation programs. Without these links the programs cannot accomplish their goals" (Axelroad and Toff, 1987, p.5).

Community-Based Service

Robinson and Bergman (1989) identified four approaches to case management. These approaches, although having many differences, shared several characteristics. One is that "services are provided in vivo (where the client is located) rather than in the clinic setting" (Robinson and Bergman, 1989, p.2).

Where intensive case management services were provided varies both between sites and within sites across the state. At most locations, it was rare for a consumer to be seen in the clinic setting, while at other sites it was rare for a consumer to be seen outside the confines of an office. The latter was explained as being the consumer's choice; and apparently the choice of most consumers at those locations. Clinic-based services, where it was a pattern, appeared to the evaluators as often fitting the classic pattern of the regularly scheduled weekly fifty-minute hour. This pattern

is a concern because development of appropriate services for non-help-seeking individuals requires a "conceptual shift from traditional clinic-based models" (Rog, 1987, p.14).

Office-based service can serve a gate keeping function by limiting service availability, much as locating an outpatient office in a more affluent area and away from transportation can limit access to services for low-income persons and people of color. Non-help-seeking mentally ill persons typically do not present themselves at a community mental health center requesting service and often do not follow through on referrals made to a clinic. Community-based service can prevent the loss of highly vulnerable persons, particularly the homeless, from the service delivery system. Engagement of these individuals necessitates seeing them in their environment. "Rather than providing services in clinics and other traditional settings that are 'stigmatizing' to mentally ill individuals, service providers need to bring the services to the individuals---on the streets and in more informal, non-mental health service settings such as shelters, drop-in centers, and specialized low-demand residences" (Rog, 1987, p.14). The evaluators reviewed one case where service was delayed for about three weeks due to the consumer not showing up for appointments at the clinic office.

Visiting with a person in his/her social world often provides the case manager with a different picture of the person. This can make for "more accurate assessments of their [the consumers] level of functioning and also of the patient-environment match" (Harris and Bergman, 1988, p.1279). This provides the opportunity for developing service plans which are more relevant to the consumer's desires in relation to their present level of functioning. More accurate assessments may avert hospitalization or intensive crisis services when residential or vocational placements fail. Further, community-based service is more likely to allow the case manager to make accurate assessments of the person's support network and have a basis for supporting the further development of this network or, if needed, helping the person develop network resources.

Seeing the consumer in his/her everyday world can have a positive impact on the person's self-image. It communicates to him/her that the case manager cares enough about them to visit them in their world. There is often less of a tendency for an individual defining themselves as a patient or client and more as a person outside the clinic. One case manager told the evaluators about the change she saw with many of the consumers she went to visit. They would have their place cleaned up and would often have coffee on when she arrived.

Harris and Bergman (1988) in a utilization analysis of case management found that more contacts were required to meet treatment objectives when consumers were seen at the clinic compared to those more often seen at locations in the community. Based on their data, they concluded that community-based service "is an effective case management strategy from both therapeutic and cost-benefit perspectives" (Harris and Bergman, 1988, p.1280).

Advocacy

Throughout the course of the state-wide review, the evaluators attempted to assess the degree to which the intensive case managers could function independently of the centers. Believing that consumer empowerment is not possible if the case manager is restrained in functioning as the consumer's advocate, the issue of independence is of central significance.

What the evaluators found was a mixed, or varying, degree of independent functioning from site to site. In some instances, the intensive case managers have complete authority to contact any and all agencies or individuals he/she and the consumer believe are relevant. In other instances, organizational problems tend to blur the fact that intensive case management services are to be an independent, separate entity within the mental health center. For example, the intensive case management program at one location is tied very closely to day treatment. A high frequency of intensive case management contacts occur within the context of the day treatment facility; both programs are supervised by the same person; and both have the same advisory committee. This suggests that many of the consumers might see the intensive case managers as a part of day treatment, and this could be fostering a dependency on the center, rather than fostering integration with the community.

The evaluators have suggested, in certain instances, that programs recognize and remove hindrances to independent functioning on the part of intensive case managers. One way to approach this is through the development of guidelines which describe the manner in which certain situations will be handled. For example, what role does the case manager take in the commitment process? To what extent is the case manager allowed to challenge other CMHC staff on treatment issues? Is the case manager allowed to bring to resolution conflicts between the consumer, the mental health center and/or other agencies?

Programs need to ensure that these and other issues will be handled in a manner which is consistent with the philosophy and values of intensive case management as delineated in the contract.

Assessment, Service Plans and Consumer Goals

As noted previously in this report, the development and maintenance of consumer case management plans was identified as being a frequently encountered problem area during the state-wide review. While many of the intensive case managers are doing an excellent job with consumers in the area of goal development and service planning, the evaluators reviewed a great many files which raised concerns about assessments, consumer goal development, and development of case management plans.

The intensive case management contract specified that the case manager would make an assessment of consumer need, with the format of this assessment left to the center. From the evaluation, it appears that in some instances the assessments were minimal. Intensive case management has as a goal assisting adults with a severe and disabling mental illness maintain community residence in the least restrictive environment. Intensive case

managers assist the consumer in obtaining the resources and services needed to maintain community residence. The case management assessment is an essential tool in this process of helping the consumer identify needed resources and services. The case management assessment is not a psychiatric, medical, or any other specialized evaluation. Any such specialized assessments, although they may be coordinated by the case manager, are to be done by a qualified professional.

The case management assessment focuses on identifying those resources that relate to consumer needs and desires and can positively effect tenure in the community. In order to be a useful tool, the case management assessment needs to include at a minimum, information about the following:

Financial resources
Residential placements and history
Vocational skills
Social support network and functioning
Health and medication management skills
Substance abuse history
Ability to perform activities of daily living
Consumer strengths, abilities, potentials, skills, and aspirations
Service linkages
Transportation

The development of a case management plan is a joint venture in which the case manager and consumer identify needed and desired resources and services. This case management plan should be an outgrowth of the assessment. In this way, the case management plan will be tailored to the consumer needs and desires and will act as a guide for case management activities on behalf of the consumer.

One of the problematic areas identified during the evaluation process was a lack of individualized case management plans in some instances. It is believed that to a large extent this can be related to an incomplete assessment and or an assessment process which is not a joint venture between the consumer and case manager. This lack of individualization may also result from not maximizing consumer involvement in plan development. It is very easy to assume that all consumers have a particular problem and automatically include it in the case management plan. It is also easy for the plan to be developed by the case manager independent of the consumer. Such a plan may be client centered in that it is related to concerns expressed by the consumer, but may not reflect consumer desires for their life.

The development of the case management assessment and the case management plan is not a static activity. One of the difficulties encountered during the evaluation was a tendency to treat the case management plan as a necessary evil---something to be developed, signed, and forgotten for three months and at times, longer. Both the case management assessment and plan need to be considered process documents that change as needs, desires, and/or conditions change. As goals are developed or altered having a target date is important. This can help ensure that goals will be periodically reviewed and altered as needed.

Having the consumer participate in this process is crucial. The development of the case management plan provides the case manager with the opportunity of helping the consumer to identify what they desire and what they have to do to achieve his/her goals. In doing this, the case manager can help the consumer perceive the goal in terms of specific measurable objectives. It is important to identify the actions (strategies) both the case manager and consumer will take in helping the consumer reach the goal. Having specific outcomes identified make it possible for the consumer and the case manager to determine when and if the goal has been obtained.

INTENSIVE CASE MANAGEMENT CONSUMERS: WHO ARE THEY?

This summary is based on information on 391 consumers who have been or are being served by the intensive case management program. Any case for which information was not available, was excluded from the analysis for that characteristic so that the number of cases reported in the table may not always total 391.

General Characteristics

The intensive case management case load consisted of almost equal numbers of females (190) and males (191). Overall, the average age of the consumers was 39.11 years, with the median age being 36.22 years. Females were significantly older than males. The female consumers' average age was 42 years, compared to 36 years for males. Most of the consumers (75%) had at least a high school education. Twenty-seven percent of the consumers had at least some college. The majority of the consumers had never been married (53%) with another thirty-two percent being divorced or separated. Only ten percent of the consumers were married at the time of beginning service. The marital status of the consumers differed with both age and gender.[2] Males are significantly more likely to have been married, separated, divorced, or widowed. Younger consumers are significantly less likely to have ever been married than are the older consumers. This finding holds for both females and males. For both younger and older consumers, males are more likely than females to have never been married, although the differences are less pronounced for the younger group of consumers.

This last finding appears particularly important for intensive case management. A spouse can be a source of social support for an individual and part of an extensive social network. These data suggest that ninety percent of the intensive case management consumers either never have had this support system or have lost it due to separation, divorce, or being widowed.

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[2]. For this and other comparisons, the consumers will be referred to as 'older' and 'younger'. Those consumers who are less than 36 years of age (the median age for the total population) are in the younger group and those 36 years or older are in the older group.

Diagnoses

Schizophrenia is the most common diagnosis, with forty-eight percent of the consumers being so diagnosed. Those with a diagnosis of schizophrenia are likely to be either paranoid type or undifferential type, accounting for eighty-eight percent of consumers so diagnosed. Males are more likely than females to have a diagnosis of schizophrenia. Consumers above the median age are more likely younger consumers to have a diagnosis of schizophrenia. For consumers above the median age, males are more likely than females to be diagnosed schizophrenic. For those below the median age, gender is not significantly related to this diagnosis. Among male consumers, those who are older are more likely to be diagnosed as schizophrenic then those who are younger. Among females, age is not related to this diagnosis.

Thirteen percent of the consumers receiving intensive case management services had a mood disorder diagnosis. Individuals having this disorder were more likely to be older females. Among younger consumers, there was no difference between females and males. However, among older consumers, males were less likely than females to have a mood disorder diagnosis. For females, those who were older were more likely to have this diagnosis, while for males, age did not differentiate those who had the diagnosis from those who did not.

Schizoaffective was the only other DSM-III-R axis I diagnosis which appeared to be related to the consumer's gender. Females were more likely to have this diagnosis.

The state defines an individual with a personality disorder as having a severe and disabling mental illness if the personality disorder causes the person to be unable to work competitively on a full-time basis or unable to maintain a residence without assistance and support by family or a public agency. One hundred twenty-one (31%) of the consumers had a personality disorder diagnosis. Forty-five (37%) also had an additional diagnosis defined by the state as an indication of severe mental illness.

Thirty-one percent of those with such a diagnosis did not have a specific personality disorder identified. Three specific personality disorders account for fifty-five percent of these diagnoses. These personality disorders are schizotypal (10%), dependent (10%), and borderline (30%).

Females are more likely to have a personality disorder diagnosis than are males. When we take age into account we find that for consumers 35 years of age and younger, females are more likely to have a personality disorder diagnosis than are males. However, for consumers 36 years of age and over, there is not relationship between gender and having a personality disorder diagnosis. Most of the specific personality disorder diagnoses do not have large enough numbers to make judgments about their relationship to gender. Three exceptions are the dependent personality disorder, the borderline personality disorder, and personality disorder not otherwise specified. The dependent personality disorder shows a clear relationship to gender with eleven of the twelve individuals with this diagnosis being female. There does not seem to be any relationship between gender and

diagnosis with the other two, with the possible exception of the 'not other wise specified' which has slightly more females than males.

There is a significant relationship between age and having a diagnosis of personality disorder. Consumers 35 years of age and younger are more likely to be diagnosed as having a personality disorder than those 36 years of age and older. When gender is taken into account, the relationship between age and having a personality disorder diagnosis holds for females, but not for males.

As with gender, it is hard to draw definite conclusions about the relationship between age and the likelihood of having any specific personality disorder diagnosis. It appears that those persons 35 years of age or younger are more likely to be diagnosed as schizotypal, borderline, personality disorder NOS than are those 36 years of age and older. Age seems to make no difference when it comes to being diagnosed as borderline personality disorder. There are too few consumers with the other personality disorder diagnoses to draw any conclusions.

Hospitalizations

Data was gathered to determine if the consumers had been hospitalized either locally or at Montana State Hospital within the year prior to their ICM case being opened. One hundred sixty-four of the 391 (42%) of the intensive case management consumers had been hospitalized during the prior year. Over half (55%) of these individuals were only hospitalized locally. Twenty percent had only been hospitalized at Montana State Hospital, while 25% had been hospitalized both locally and at Montana State Hospital. A slight relationship exists between diagnosis and when an individual is hospitalized. Those individuals with a diagnosis of personality disorder are more likely to be hospitalized locally or both locally and at Montana State Hospital.

Dually Diagnosed

Data was gathered concerning developmental disabilities and substance abuse. With both, what will be presented is information concerning the numbers of consumers for whom these issues impact functioning in the community, regardless of whether the disorder has been formally diagnosed. Overall, eighteen percent of the consumers were developmentally disabled and thirty-seven percent have substance abuse problems. This thirty-seven percent fits with national estimates that "between one-third and one-half of all patients in psychiatric treatment also abuse alcohol or drugs" (Carey, 1989, p.341).

Males are much more likely to have problems with the abuse of alcohol or drugs than are females. Fifty-one percent of the male consumers have substance abuse problems compared to twenty-four percent of the females. Controlling for age of the consumer, it is found that males are still more likely to have substance abuse problems. However, this relationship is not as strong among consumers 35 years of age and younger as for those 36 years and older. There is a tendency for those who have substance abuse problems to be younger, although this relationship was not significant. For

females, those 35 years of age and younger are much more likely to have difficulties with abuse of alcohol and other drugs. No relationship existed between age and substance abuse for the males.

There was a very significant relationship between the age of the consumer and being developmentally disabled. Younger consumers were much more likely to developmentally disabled than those 36 years of age and over. No relationship was found between gender and being developmentally disabled. The relationship between age and developmental disability held when controlling for gender.

Prior contact with the Mental Health Center

Serving non-help-seeking mentally ill is a high priority of the intensive case management program. There is no single indicator of the degree to which the program targets non-help-seeking mentally ill persons. Whether or not a consumer was a client of the mental health center at the time the case was opened is one indicator of non-help-seeking. Two hundred seventy-five, or seventy percent, were center clients at the time they began intensive case management services. If the consumer was a mental health center client information was obtained about the number of different services received during the three month period prior to the case being opened. There was no measure of the intensity of any service received, so that a person who attended day treatment once during the three month period would be recorded the same as a person who attended day treatment on a daily basis. The consumers who were center clients had received an average of 1.4 different services, ranging from no services to five different services. The majority (54%) had received one service, while twelve percent received no service and thirty-four percent received two or more different services. In terms of the specific services the most frequent were outpatient individual (45%), day treatment (48%), and community living support (27%). Inadvertently emergency services and medication clinic were omitted from the list of possible services. It is possible that in some instances these services were reported as outpatient individual. Among the consumers who had received only one service, it was outpatient individual forty-three percent of the time.

Case managers indicated if a consumer had been resistent to receiving mental health services. This can be another indicator of non-help-seeking. Forty-six percent of all consumers were judged to have been resistent to receiving mental health services.

Homelessness

A primary concern of intensive case management is the provision of service to homeless mentally ill. At the time a consumer's case management file was opened, the case manager was to indicate if the consumer was 'homeless' or 'at risk of becoming homeless'. It is uncertain how accurate this data is because initially there was no operational definition of what constituted 'homelessness' and 'at risk of becoming homeless'. Data regarding homelessness was missing in a large number of cases due to the lack of a definition. Based on information from the intensive case management sites, it was decided to treat those cases in which this data was

missing as being 'at risk of becoming homeless'. Data was also gathered concerning the residential status of the consumer at the time the case was opened. This information was used to look at the homeless who were either living on the streets or were at a mission or shelter.

Eighty, or 20 percent, of the intensive case management consumers were identified as being homeless. The only factor that differentiated the homeless from those in danger of becoming homeless was prior contact with the mental health center. Seventy-nine percent of those who were in danger of becoming homeless were center clients at the time intensive case management services began. However, sixty-two percent of those who were homeless were not center clients at the time intensive case management services began.

The definition of homeless comes from the Stewart B. McKinney Act and is broad in relation to persons who are mentally ill. A person in a mental health group home or hospitalized for psychiatric reasons is considered homeless. Within this larger group are those persons who are more traditionally viewed as homeless---either living on the streets or in the shelter or mission. Based on data about the consumer's residential status at the time services began, fifty-three (14%) of the consumers were either on the streets or in shelters. Among this group eighty percent were <u>not</u> center clients at the time services began. One interesting finding relates to the gender of the homeless population. They were just as likely to be female as to be male.

SUMMARY

We hope this report provides a mechanism for case management programs and advisory committees to use in evaluating the local intensive case management programs. We feel that as a group the case managers are the strongest part of the intensive case management service. They are a dedicated group of individuals who show a great deal of compassion and concern for the homeless mentally ill. We wish to thank all of the case managers, the supervisors, the advisory committee members, the advocates, the consumers, and the CMHC directors who spent time with us. Their input is what formed the basis of this evaluation report.

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APPENDIX A

Definition of Homelessness and At Risk of Homelessness

The following are definitions of homeless and at significant risk of becoming homeless for the purposes of the intensive case management program. In order to be served by this program a person must be homeless or at significant risk of becoming homeless.

HOMELESS

Present living arrangements are one of the following:

- Public or private place not designed to be used as regular sleeping accommodations
- Congregate Shelter
- SRO (Quarters rented on a short-term basis [day or week] and individual has no other fixed or regular nighttime residence)
- In jail [If individual has no fixed or regular nighttime residence to return to]
- Psychiatric hospital [If individual has no fixed or regular nighttime residence to return to]
- MH Group Home or Transitional Living Facility

AT SIGNIFICANT RISK OF BECOMING HOMELESS

One of the following describes the persons present living arrangements:

- Last two residences [not including present residence] were each occupied for less than one month.
- Residential history that indicates two or more instances of homelessness in last year [Excluding psychiatric hospitalizations and transitional or group home housing] for the mentally ill combined with less than six months in present residence and two or more risk factors are present.
- Recently left [within last 90 days] psychiatric hospital, group home, or transitional living facility and presently living independently, and two or more risk factors are present.
- History of transient life style [Lived at present and prior residence each six months or less, a history of changing residences frequently, and interpersonal difficulties and/or behavior patterns that have led to evictions in the past] with three or more risk factors present.
- An individual who has had a major disruption in their life [divorce, thrown out of parent's home, etc.] or is facing a major disruption [with little or no planning for the change] and has three or more risk factors present.

RISK FACTORS

- Isolated with inadequate social support network
  - Not Married
  - Few friends
  - Infrequent or no contact with relatives
  - Little or no contact with community groups

- History of multiple psychiatric hospitalizations
- Alcohol and/or drug problems
- Poor independent living skills
- Money management deficits
- Poor economic supports
  - No stable income source
  - Family only means of financial support
  - Only income from GA

- Minimal vocational skills
- Borderline intellectual functioning
- Refusal of Medical/Mental Health care

There may be circumstances other than the above that create a situation where the individual is at risk of being homeless. If this is the case, the factors that make the individual at substantial risk of being homeless must be documented.

APPENDIX B

Characteristics of Intensive Case Management

Consumers Served as of April 15, 1989

TABLE 3
Characteristics of Intensive Case Management Consumers

	Number	Percent
Consumers gender		
Female	190	50%
Male	191	50%
TOTAL	381	100%
Consumers age		
Less than 18	1	0%
18-25	55	15%
26-35	126	34%
36-45	91	24%
46-55	61	16%
56-65	23	6%
66+	17	5%
TOTAL	374	100%
Consumers education		
Less than high school	93	25%
high school/GED	161	44%
some college	79	21%
vocational training	16	4%
college graduate	14	4%
post graduate	5	1%
TOTAL	368	100%
Consumers marital status		
married	39	10%
never married	199	53%
divorced	99	26%
widowed	17	4%
separated	25	7%
TOTAL	379	100%

TABLE 4
Consumers Gender by Age

	Consumers age							Row total
	Less than 18	18-25	26-35	36-45	46-55	56-65	66+	
Consumers gender								
Female.....	1	21	55	37	43	13	12	182
	100%	39%	44%	42%	73%	59%	75%	50%
Male.....		33	70	51	16	9	4	183
		61%	56%	58%	27%	41%	25%	50%
Column Total.....	1	54	125	88	59	22	16	365
	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 5
Consumers Age by Gender

	Consumers Gender		Row total
	Female	Male	
Consumers age			
Less than 18.....	1		1
	1%		0%
18-25.....	21	33	54
	12%	18%	15%
26-35.....	55	70	125
	30%	38%	34%
36-45.....	37	51	88
	20%	28%	24%
46-55.....	43	16	59
	24%	9%	16%
56-65.....	13	9	22
	7%	5%	6%
66+.....	12	4	16
	7%	2%	4%
Column total.....	182	183	365
	100%	100%	100%

TABLE 6

Consumer's Education and Marital Status by Gender and Age

	Consumer's Gender		Row	Consumer's Age		Row
	Female	Male	Total	35 yrs & under	36 yrs & over	Total
Consumer's Marital Status						
Married	24	14	38	17	20	37
	13%	8%	10%	9%	11%	10%
Never Married	56	140	196	129	65	194
	30%	76%	53%	72%	35%	53%
Divorced	78	19	97	28	66	94
	42%	10%	26%	16%	36%	26%
Widowed	13	3	16		16	16
	7%	2%	4%		9%	4%
Separated	14	9	23	6	18	24
	8%	5%	6%	3%	10%	7%
Column Total	185	185.	370	180	185	365
	100%	100%	100%	100%	100%	100%
Consumer's Education						
Less than high school	41	50	91	49	42	91
	23%	28%	25%	28%	23%	26%
High School/GED	81	77	158	80	77	157
	45%	43%	44%	45%	43%	44%
Some College	35	41	76	36	39	75
	20%	23%	21%	20%	22%	21%
Vocational Training	11	5	16	7	9	16
	6%	3%	4%	4%	5%	4%
College Graduate	9	5	14	3	10	13
	5%	3%	4%	2%	6%	4%
Post Graduate	2	2	4	1	3	4
	1%	1%	1%	1%	2%	1%
Column Total	179	180	359	176	180	356
	100%	100%	100%	100%	100%	100%

TABLE 7
Consumer's Marital Status by Age by Gender

	Consumer's Age				Total
	35 yrs & under Consumer's Gender		36 yrs & over Consumer's Gender		
	Female	Male	Female	Male	
Consumer's Marital Status					
Married	9	8	13	6	36
	12%	8%	13%	8%	10%
Never Married	39	88	15	49	191
	51%	86%	15%	64%	54%
Divorced	23	5	51	13	92
	30%	5%	50%	17%	26%
Widowed			13	2	15
			13%	3%	4%
Separated	5	1	9	7	22
	7%	1%	9%	9%	6%
Column Total	76	102	101	77	356
	100%	100%	100%	100%	100%

TABLE 8
Consumer's Marital Status by Gender by Age

	Consumer's Gender				
	Female Consumer's Age		Male Consumer's Age		Total
	35 yrs & under	36 yrs & over	35 yrs & under	36 yrs & over	
Consumer's Marital Status					
Married	9	13	8	6	36
	12%	13%	8%	8%	10%
Never Married	39	15	88	49	191
	51%	15%	86%	64%	54%
Divorced	23	51	5	13	92
	30%	50%	5%	17%	26%
Widowed		13		2	15
		13%		3%	4%
Separated	5	9	1	7	22
	7%	9%	1%	9%	6%
Column Total	76	101	102	77	356
	100%	100%	100%	100%	100%

TABLE 9
Consumer Diagnoses

	Number	Percent
Axis I SMI Diagnoses		
Schizophrenic Disorder	186	47.6%
Mood Disorder	51	13.0%
Psychotic Disorder	27	6.9%
Other SMI Disorder	16	4.1%
No Axis I SMI Disorder	111	28.4%
Total	391	100.0%
Personality Disorders		
Schizotypal	12	3.1%
Dependent	12	3.1%
Borderline	36	9.2%
Other Personality Disorder	24	6.2%
Personality Disorder, NOS	37	9.5%
No Personality Disorder Diagnosis . .	269	69.0%
Total	390	100.0%

TABLE 10
Consumer Diagnosis by Age and Gender

	Consumer's Gender		Row	Consumer's Age		Row
	Female	Male	Total	35 yrs & under	36 yrs & over	Total
Axis I SMI Diagnoses						
Schizophrenic Disorder . . .	77	107	184	76	104	180
	41%	56%	48%	42%	54%	48%
Mood Disorder	33	16	49	15	33	48
	17%	8%	13%	8%	17%	13%
Psychotic Disorder	16	10	26	15	10	25
	8%	5%	7%	8%	5%	7%
Other SMI Disorder	9	6	15	8	8	16
	5%	3%	4%	4%	4%	4%
Column Total	190	191	381	182	192	374
	100%	100%	100%	100%	100%	100%
Personality Disorders						
Schizotypal	6	5	11	10	1	11
	3%	3%	3%	5%	1%	3%
Dependent	11	1	12	5	7	12
	6%	1%	3%	3%	4%	3%
Borderline	18	16	34	21	15	36
	9%	8%	9%	12%	8%	10%
Other Personality Disorder .	13	11	24	13	11	24
	7%	6%	6%	7%	6%	6%
Personality Disorder, NOS . .	22	15	37	22	13	35
	12%	8%	10%	12%	7%	9%
No Personality Disorder Diagnosis	120	142	262	111	145	256
	63%	75%	69%	61%	76%	68%
Column Total	190	190	380	182	192	374
	100%	100%	100%	100%	100%	100%

TABLE 11
Schizophrenic Disorder or Mood Disorder Diagnosis
by Age and Gender

	Consumer's Gender		Row	Consumer's Age		Row
	Female	Male	Total	35 yrs & under	36 yrs & over	Total
Schizophrenic Disorder Diagnosis						
No	113	84	197	106	88	194
	59%	44%	52%	58%	46%	52%
Yes	77	107	184	76	104	180
	41%	56%	48%	42%	54%	48%
Column Total	190	191	381	182	192	374
	100%	100%	100%	100%	100%	100%
Mood Disorder Diagnosis						
No	157	175	332	167	159	326
	83%	92%	87%	92%	83%	87%
Yes	33	16	49	15	33	48
	17%	8%	13%	8%	17%	13%
Column Total	190	191	381	182	192	374
	100%	100%	100%	100%	100%	100%

TABLE 12
Schizophrenic Disorder Diagnosis by Age by Gender

	Consumer's Age				Total
	35 yrs & under Consumer's Gender		36 yrs & over Consumer's Gender		
	Female	Male	Female	Male	
Schizophrenic Disorder Diagnosis					
No	50	54	58	25	187
	65%	52%	55%	31%	51%
Yes	27	49	47	55	178
	35%	48%	45%	69%	49%
Column Total	77	103	105	80	365
	100%	100%	100%	100%	100%

TABLE 13
Schizophrenic Disorder Diagnosis by Gender by Age

	Consumer's Gender				Total
	Female Consumer's Age		Male Consumer's Age		
	35 yrs & under	36 yrs & over	35 yrs & under	36 yrs & over	
Schizophrenic Disorder Diagnosis					
No	50	58	54	25	187
	65%	55%	52%	31%	51%
Yes	27	47	49	55	178
	35%	45%	48%	69%	49%
Column Total	77	105	103	80	365
	100%	100%	100%	100%	100%

TABLE 14
Mood Disorder Diagnosis by Age by Gender

	Consumer's Age				Total
	35 yrs & under Consumer's Gender		36 yrs & over Consumer's Gender		
	Female	Male	Female	Male	
Mood Disorder Diagnosis					
No	69	96	81	73	319
	90%	93%	77%	91%	87%
Yes	8	7	24	7	46
	10%	7%	23%	9%	13%
Column Total	77	103	105	80	365
	100%	100%	100%	100%	100%

TABLE 15
Mood Disorder Diagnosis by Gender by Age

	Consumer's Gender				Total
	Female Consumer's Age		Male Consumer's Age		
	35 yrs & under	36 yrs & over	35 yrs & under	36 yrs & over	
Mood Disorder Diagnosis					
No	69	81	96	73	319
	90%	77%	93%	91%	87%
Yes	8	24	7	7	46
	10%	23%	7%	9%	13%
Column Total	77	105	103	80	365
	100%	100%	100%	100%	100%

TABLE 16
Number of Consumers Hospitalized During Year Prior to Intensive Case Management Services by Location

	Number	Percent
Hospitalization		
Local Hospital Only	90	23.0%
Montana State Hospital Only	33	8.4%
Both Local and Montana State Hospital	41	10.5%
Not Hospitalized	227	58.1%
Total	391	100.0%

TABLE 17
Hospitalization by Axis I SMI Diagnosis

	Axis I SMI Diagnosis					Row Total
	Schizo-phrenic Disorder	Mood Disorder	Psy-chotic Disorder	Other SMI Disorder	No Axis I Disorder	
Hospitalization						
Local Hospital Only	42	16	9	3	20	90
	23%	31%	33%	19%	18%	23%
Montana State Hospital Only .	23	3		1	6	33
	12%	6%		6%	5%	8%
Both Local and Montana State Hospital . . .	17	3	7	3	11	41
	9%	6%	26%	19%	10%	10%
Not Hospitalized	104	29	11	9	74	227
	56%	57%	41%	56%	67%	58%
Column Total	186	51	27	16	111	391
	100%	100%	100%	100%	100%	100%

TABLE 18
Hospitalization by Personality Disorder Diagnosis

	Personality Disorders						Row Total
	Schizo-typal	Dependent	Border-Line	Other Per-sonality Disorder	Per-sonality Disorder NOS	No Per-sonality Disorder Diagnosis	
Hospitalization							
Local Hospital Only	2	5	6	6	10	61	90
	17%	42%	17%	25%	27%	23%	23%
Montana State Hospital Only . . .			1		2	30	33
			3%		5%	11%	8%
Both Local and Montana State Hospital	2	1	6	1	3	28	41
	17%	8%	17%	4%	8%	10%	11%
Not Hospitalized . .	8	6	23	17	22	150	226
	67%	50%	64%	71%	59%	56%	58%
Column Total	12	12	36	24	37	269	390
	100%	100%	100%	100%	100%	100%	100%

TABLE 19
Consumer's Abuse of Drugs and/or Alcohol by Gender and Age

	Consumer's Gender		Row	Consumer's Age		Row
	Female	Male	Total	35 yrs & under	36 yrs & over	Total
Substance Abuse						
No	145	93	238	106	131	237
	76%	49%	62%	58%	68%	63%
Yes	45	98	143	76	61	137
	24%	51%	38%	42%	32%	37%
Column Total	190	191	381	182	192	374
	100%	100%	100%	100%	100%	100%

TABLE 20
Consumer's Abuse of Drugs and/or Alcohol by Age by Gender

	Consumer's Age				Total
	35 yrs & under Consumer's Gender		36 yrs & over Consumer's Gender		
	Female	Male	Female	Male	
Substance Abuse					
No	52	53	89	37	231
	68%	51%	85%	46%	63%
Yes	25	50	16	43	134
	32%	49%	15%	54%	37%
Column Total	77	103	105	80	365
	100%	100%	100%	100%	100%

TABLE 21
Consumer's Abuse of Drugs and/or Alcohol by Gender by Age

	Consumer's Gender				Total
	Female		Male		
	Consumer's Age		Consumer's Age		
	35 yrs & under	36 yrs & over	35 yrs & under	36 yrs & over	
Substance Abuse					
No	52	89	53	37	231
	68%	85%	51%	46%	63%
Yes	25	16	50	43	134
	32%	15%	49%	54%	37%
Column Total	77	105	103	80	365
	100%	100%	100%	100%	100%

TABLE 22
Developmentally Disabled Consumers by Gender and Age

	Consumer's Gender		Row	Consumer's Age		Row
	Female	Male	Total	35 yrs & under	36 yrs & over	Total
Developmentally Disabled						
No	161	150	311	131	173	304
	85%	79%	82%	72%	90%	81%
Yes	29	41	70	51	19	70
	15%	21%	18%	28%	10%	19%
Column Total	190	191	381	182	192	374
	100%	100%	100%	100%	100%	100%

TABLE 23

CMHC Client Status at Time Intensive Case Management Services Began and Services Received During the 3 Month Period Before Opening

	Number	Percent
CMHC Client		
Yes	275	70%
No	116	30%
Total	391	100%
Services		
Outpatient Individual	124	45%
Outpatient Group	12	4%
Day Treatment	131	48%
Community Living Support	74	27%
Transitional Living	24	9%
Inpatient	18	6%

Number of CMHC clients is base for percent on services and service does not add up to 100% as client could receive more than one service.

TABLE 24

Number of Different Services Received During the 3 Months Prior to Intensive Case Management Services For CMHC Clients

	Number	Percent
Number of Services		
None	34	12%
One	148	54%
Two	61	22%
Three	17	6%
Four	12	4%
Five	3	1%
Column Total	275	100%
Mean	1.40	
Standard Deviation	1.00	

TABLE 25
Consumers Judged to be Non-Help-Seeking

	Number	Percent
Non-help-seeking		
No	209	53%
Yes	182	47%
Total	391	100%

TABLE 26
Homelessness Status of Consumers

	Number	Percent
Homeless Status of Respondents		
Homeless	80	20%
At Risk of Homelessness	311	80%
Total	391	100%

TABLE 27
Homelessness Status of Consumers by Gender and Age

	Consumer's Gender		Row	Consumer's Age		Row
	Female	Male	Total	35 yrs & under	36 yrs & over	Total
Homeless Status of Respondents						
Homeless	33	43	76	36	35	71
	17%	23%	20%	20%	18%	19%
At Risk of Homelessness	157	148	305	146	157	303
	83%	77%	80%	80%	82%	81%
Column Total	190	191	381	182	192	374
	100%	100%	100%	100%	100%	100%

TABLE 28
Homelessness Status by Center Client at Time
Intensive Case Management Services Began

	CMHC Client at Time ICM Services Began		Row Total
	Yes	No	
Homeless Status of Respondents			
Homeless	30 11%	50 43%	80 20%
At Risk of Homelessness	245 89%	66 57%	311 80%
Column Total	275 100%	116 100%	391 100%

APPENDIX C

Selected Characteristics of Intensive Case Management
Consumers served as of April 15, 1989

by Community Mental Health Region
and
Intensive Case Management Site

TABLE 29
Gender and Age of Consumers by CMHC Region

	Mental Health Region					Row
	1	2	3	4	5	Total
Consumer's Gender						
Female	24	54	32	32	48	190
	53%	64%	43%	44%	46%	50%
Male	21	31	42	41	56	191
	47%	36%	57%	56%	54%	50%
Column Total	45	85	74	73	104	381
	100%	100%	100%	100%	100%	100%
Consumer's Age						
Less than 18		1				1
		1%				1%
18-25	7	14	19	10	5	55
	16%	18%	24%	14%	5%	15%
26-35	13	25	20	25	43	126
	30%	32%	26%	34%	43%	34%
36-45	14	14	14	19	30	91
	32%	18%	18%	26%	30%	24%
46-55	9	13	14	12	13	61
	20%	16%	18%	16%	13%	16%
56-65	1	5	5	6	6	23
	2%	6%	6%	8%	6%	6%
66+		7	6	1	3	17
		9%	8%	1%	3%	5%
Column Total	44	79	78	73	100	374
	100%	100%	100%	100%	100%	100%

TABLE 30
Marital Status and Education of Consumers by CMHC Region

	Mental Health Region					Row
	1	2	3	4	5	Total
Consumer's Marital Status						
Married	5	7	6	6	15	39
	11%	9%	8%	8%	15%	10%
Never Married	20	43	44	36	56	199
	44%	54%	56%	49%	54%	53%
Divorced	11	17	17	27	27	99
	24%	22%	22%	36%	26%	26%
Widowed	2	7	4	3	1	17
	4%	9%	5%	4%	1%	4%
Separated	7	5	7	2	4	25
	16%	6%	9%	3%	4%	7%
Column Total	45	79	78	74	103	379
	100%	100%	100%	100%	100%	100%
Consumer's Education						
Less than high school	15	26	27	11	14	93
	35%	33%	35%	16%	14%	25%
High School/GED	17	32	29	35	48	161
	40%	41%	38%	50%	48%	44%
Some College	5	14	12	18	30	79
	12%	18%	16%	26%	30%	21%
Vocational Training	4	4	4	3	1	16
	9%	5%	5%	4%	1%	4%
College Graduate	1	2	2	3	6	14
	2%	3%	3%	4%	6%	4%
Post Graduate	1		3		1	5
	2%		4%		1%	1%
Column Total	43	78	77	70	100	368
	100%	100%	100%	100%	100%	100%

TABLE 31
Consumer Diagnoses by CMHC Region

	Mental Health Region					Row
	1	2	3	4	5	Total
Axis I SMI Diagnoses						
Schizophrenic Disorder . . .	18	43	30	30	65	186
	39%	51%	38%	39%	62%	48%
Mood Disorder	12	7	10	12	10	51
	26%	8%	13%	16%	10%	13%
Psychotic Disorder	2	2	5	5	13	27
	4%	2%	6%	6%	12%	7%
Other SMI Disorder	2	4	3	2	5	16
	4%	5%	4%	3%	5%	4%
No Axis I SMI Disorder . . .	12	29	30	28	12	111
	26%	34%	38%	36%	11%	28%
Column Total	46	85	78	77	105	391
	100%	100%	100%	100%	100%	100%
Personality Disorders						
Schizotypal	1	2	3	4	2	12
	2%	2%	4%	5%	2%	3%
Dependent	2	4	5	1		12
	4%	5%	6%	1%		3%
Borderline	7	9	8	9	3	36
	15%	11%	10%	12%	3%	9%
Other Personality Disorder .	5	8	2	6	3	24
	11%	10%	3%	8%	3%	6%
Personality Disorder, NOS . .	3	10	8	5	11	37
	7%	12%	10%	6%	10%	9%
No Personality Disorder Diagnosis	28	51	52	52	86	269
	61%	61%	57%	68%	82%	69%
Column Total	46	84	78	77	105	390
	100%	100%	100%	100%	100%	100%

TABLE 32
Hospitalization of Consumers by CMHC Region

	Mental Health Region 1	2	3	4	5	Row Total
Hospitalization						
Local Hospital Only	8	20	21	20	21	90
	17%	24%	27%	26%	20%	23%
Montana State Hospital Only .	1	2	5	7	18	33
	2%	2%	6%	9%	17%	8%
Both Local and Montana State Hospital . . .	4	11	8	11	7	41
	9%	13%	10%	14%	7%	10%
Not Hospitalized	33	52	44	39	59	227
	72%	61%	56%	51%	56%	58%
Column Total	46	85	78	77	105	391
	100%	100%	100%	100%	100%	100%

TABLE 33
Dually Diagnosed Consumers by CMHC Region

	Mental Health Region 1	2	3	4	5	Row Total
Substance Abuse						
No	35	59	50	34	67	245
	76%	69%	64%	44%	64%	63%
Yes	11	26	28	43	38	146
	24%	31%	36%	56%	36%	37%
Column Total	46	85	78	77	105	391
	100%	100%	100%	100%	100%	100%
Developmentally Disabled						
No	31	67	57	71	94	320
	67%	79%	73%	92%	90%	82%
Yes	15	18	21	6	11	71
	33%	21%	27%	8%	10%	18%
Column Total	46	85	78	77	105	391
	100%	100%	100%	100%	100%	100%

TABLE 34
Consumers Judged as Non-Help-Seeking by CMHC Region

	Mental Health Region					Row
	1	2	3	4	5	Total
Non-help-seeking						
No	29	41	53	24	62	209
	63%	48%	68%	31%	59%	53%
Yes	17	44	25	53	43	182
	37%	52%	32%	69%	41%	47%
Column Total	46	85	78	77	105	391
	100%	100%	100%	100%	100%	100%

TABLE 35
Homelessness Status of Consumers by CMHC Region

	Mental Health Region					Row
	1	2	3	4	5	Total
Homeless Status of Respondents						
Homeless	3	29	14	17	17	80
	7%	34%	18%	22%	16%	20%
At Risk of Homelessness . . .	43	56	64	60	88	311
	93%	66%	82%	78%	84%	80%
Column Total	46	85	78	77	105	391
		100%		100%		100%

TABLE 36
Gender and Age of Consumers by ICM Site

	Case management Program Site										Row Total
	Miles City	Glen-dive	Great Falls	Havre	Bil-lings	Helena	Butte	Living-ston	Mis-soula	Kalis-pell	
Consumer's Gender											
Female	13	11	45	9	32	12	11	9	25	23	190
	43%	73%	63%	54%	43%	38%	44%	56%	41%	53%	50%
Male	17	4	26	5	42	20	14	7	36	20	191
	57%	27%	37%	36%	57%	63%	56%	44%	59%	47%	50%
Column Total	30	15	71	14	74	32	25	16	61	43	381
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consumer's Age											
Less than 18				1							1
				8%							0%
18-25	3	4	12	2	19	8	1	1	3	2	55
	11%	25%	18%	15%	24%	23%	4%	7%	5%	5%	15%
26-35	10	3	21	4	20	12	7	6	28	15	126
	36%	19%	32%	31%	26%	34%	30%	40%	47%	37%	34%
36-45	8	6	10	4	14	9	8	2	15	15	91
	29%	38%	15%	31%	18%	26%	35%	13%	25%	37%	24%
46-55	6	3	12	1	14	5	4	3	9	4	61
	21%	19%	18%	8%	18%	148	17%	20%	15%	10%	16%
56-65	1		5		5	1	3	2	3	3	23
	4%		8%		6%	3%	3%	13%	5%	7%	6%
66+			6	1	6			1	1	2	17
			9%	8%	8%			7%	2%	5%	5%
Column Total	28	16	66	13	78	35	23	15	59	41	374
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 37

Marital Status and Education of Consumers by ICM Site

	Case management Program Site										Row
	Miles City	Glen-dive	Great Falls	Havre	Bil-lings	Helena	Butte	Living-ston	Mis-soula	Kalis-pell	Total
Consumer's Marital Status											
Married	4	1	4	3	6	2	3	1	11	4	39
	14%	6%	6%	21%	8%	6%	13%	6%	18%	10%	10%
Never Married	12	8	36	7	44	21	8	7	40	16	199
	41%	50%	55%	50%	56%	62%	33%	44%	66%	38%	53%
Divorced	7	4	15	2	17	10	11	6	10	17	99
	24%	25%	23%	14%	22%	29%	46%	38%	16%	40%	26%
Widowed	1	1	5	2	4		1	2		1	17
	3%	6%	8%	14%	5%		4%	13%		2%	4%
Separated	5	2	5		7	1	1			4	25
	17%	13%	8%		9%	3%	4%			10%	7%
Column Total	29	16	65	14	78	34	24	16	61	42	379
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consumer's Education											
Less than high school	7	8	21	5	27	5	4	2	7	7	93
	26%	50%	32%	38%	35%	15%	20%	13%	11%	18%	25%
High School/GED	13	4	25	7	29	12	12	11	30	18	161
	48%	25%	38%	54%	38%	35%	60%	69%	49%	46%	44%
Some College	3	2	14		12	13	2	3	18	12	79
	11%	13%	22%		16%	38%	10%	19%	30%	31%	21%
Vocational Training	3	1	4		4	3			1		16
	11%	6%	6%		5%	9%			2%		4%
College Graduate		1	1	1	2	1	2		5	1	14
		6%	2%	8%	3%	3%	10%		8%	3%	4%
Post Graduate	1				3					1	5
	4%				4%					3%	1%
Column Total	27	16	65	13	77	34	20	16	61	29	368
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 38
Consumer Diagnoses by ICM Site

	Case management Program Site										Row
	Miles City	Glen-dive	Great Falls	Havre	Bil-lings	Helena	Butte	Living-ston	Mis-soula	Kalis-pell	Total
Axis I SMI Diagnoses											
Schizophrenic Disorder . . .	12	6	33	10	30	13	11	6	40	25	186
	40%	38%	46%	71%	38%	36%	44%	38%	65%	58%	48%
Mood Disorder	7	5	6	1	10	4	5	3	6	4	51
	23%	31%	8%	7%	13%	11%	20%	19%	10%	9%	13%
Psychotic Disorder	2		2		5	3	2		10	3	27
	7%		3%		6%	8%	8%		16%	7%	7%
Other SMI Disorder	2		3	1	3	1	1		2	3	16
	7%		4%	7%	4%	3%	4%		3%	7%	4%
No Axis I SMI Disorder . . .	7	5	27	2	30	15	6	7	4	8	111
	23%	31%	38%	14%	38%	42%	24%	44%	6%	19%	28%
Column Total	30	16	71	14	78	36	25	16	62	43	391
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Personality Disorders											
Schizotypal		1	2		3	2	1	1	1	1	12
		6%	3%		4%	6%	4%	6%	2%	2%	3%
Dependent		2	4		5	1					12
		13%	6%		6%	3%					3%
Borderline	5	2	9		8	3	2	4	1	2	36
	17%	13%	13%		10%	8%	8%	25%	2%	5%	9%
Other Personality Disorder .	5		8		2	3		3		3	24
	17%		11%		3%	8%		19%		7%	6%
Personality Disorder, NOS . .	3		9	1	8	4		1		11	37
	10%		13%	7%	10%	11%		6%		26%	9%
No Personality Disorder Diagnosis	17	11	38	13	52	23	22	7	60	26	269
	57%	69%	54%	93%	67%	64%	88%	44%	97%	60%	69%
Column Total	30	16	70	14	78	36	25	16	62	43	390
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 39
Hospitalization of Consumers by ICM Site

	Case management Program Site										Row
	Miles City	Glen-dive	Great Falls	Havre	Bil-lings	Helena	Butte	Living-ston	Mis-soula	Kalis-pell	Total
Hospitalization											
Local Hospital Only	5	3	14	6	21	8	6	6	15	6	90
	17%	19%	20%	43%	27%	22%	24%	38%	24%	14%	23%
Montana State Hospital Only .	1		1	1	5	2	4	1	14	4	33
	3%		1%	7%	6%	6%	16%	6%	23%	9%	8%
Both Local and Montana State Hospital . . .	3	1	9	2	8	7	3	1	6	1	41
	10%	6%	13%	14%	10%	19%	12%	6%	10%	2%	10%
Not Hospitalized	21	12	47	5	44	19	12	8	27	32	227
	70%	75%	66%	36%	56%	53%	48%	50%	44%	74%	58%
Column Total	30	16	71	14	78	36	25	16	62	43	391
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 40
Dually Diagnosed Consumers by ICM Site

	Case management Program Site										Row
	Miles City	Glen-dive	Great Falls	Havre	Bil-lings	Helena	Butte	Living-ston	Mis-soula	Kalis-pell	Total
Substance Abuse											
No	21	14	51	8	50	19	7	8	43	24	245
	70%	88%	72%	57%	64%	53%	28%	50%	69%	56%	63%
Yes	9	2	20	6	28	17	18	8	19	19	146
	30%	13%	28%	43%	36%	47%	72%	50%	31%	44%	37%
Column Total	30	16	71	14	78	36	25	16	62	43	391
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Developmentally Disabled											
No	22	9	59	8	57	33	24	14	56	38	320
	73%	56%	83%	57%	73%	92%	96%	88%	90%	88%	82%
Yes	8	7	12	6	21	3	1	2	6	5	71
	27%	44%	17%	43%	27%	8%	4%	13%	10%	12%	18%
Column Total	30	16	71	14	78	36	25	16	62	43	391
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 41
Consumers Judged as Non-Help-Seeking by ICM Site

	Case management Program Site										Row
	Miles City	Glen-dive	Great Falls	Havre	Bil-lings	Helena	Butte	Living-ston	Mis-soula	Kalis-pell	Total
Non-help-seeking											
No	21	8	30	11	53	19	1	4	36	26	209
	70%	50%	42%	79%	68%	53%	4%	25%	58%	60%	53%
Yes	9	8	41	3	25	17	24	12	26	17	182
	30%	50%	58%	21%	32%	47%	96%	75%	42%	40%	47%
Column Total	30	16	71	14	78	36	25	16	62	43	391
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 42
Homelessness Status of Consumers by ICM Site

	Case management Program Site										Row
	Miles City	Glen-dive	Great Falls	Havre	Bil-lings	Helena	Butte	Living-ston	Mis-soula	Kalis-pell	Total
Homeless Status of Respondents											
Homeless	1	2	29		14	14	1	2	8	9	80
	3%	13%	41%		18%	39%	4$	13%	13%	21%	20%
At Risk of Homelessness . . .	29	14	42	14	64	22	24	14	54	34	311
	97%	88%	59%	100%	82%	61%	96%	88%	87%	79%	80%
Column Total	30	16	71	14	78	36	25	16	62	43	391
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 43

CMHC Client Status at Time Intensive Case Management Services Began and Services Received During Three Month Period Before Opening By CMHC Region

	Mental Health Region										Total	
	I		II		III		IV		V			
	N	%	N	%	N	%	N	%	N	%	N	%
Center Client												
Yes	40	87%	56	66%	56	72%	61	79%	62	59%	275	70%
No	5	13%	29	34%	22	28%	16	21%	43	41%	116	30%
Column Total	46	100%	85	100%	78	20%	77	100%	105	100%	391	100%
Service Received												
Outpatient Individual .	27	68%	35	62%	22	39%	22	36%	18	29%	124	45
Outpatient Group	2	5%	4	7%	3	5%	2	3%	1	2%	12	4%
Day Treatment	30	78%	24	43%	13	23%	49	890%	17	24%	131	48%
Community Living Support	10	25%	11	20%	19	32%	22	36%	13	21%	74	27%
Transitional Living . .	1	3%	5	9%	6	11%	4	7%	2	3%	18	6%
Inpatient	11	28%			5	9%	8	13%			24	9%

Services received do not add up because a client could have received more than one service. Number of center clients is base for percent on service received.

TABLE 44
Number of Different Services Received During the
3 Months Prior to Intensive Case Management Services
For CMHC Clients By CMHC Region

	Mental Health Region										Total	
	I		II		III		IV		V			
	N	%	N	%	N	%	N	%	N	%	N	%
Number of Services												
None	3	8%	2	4%	6	11%	3	5%	20	32%	34	12%
One	16	40%	34	61%	36	64%	26	43%	36	58%	148	54%
Two	8	50%	16	29%	12	21%	20	33%	5	8%	61	22%
Three	5	12%	3	5%	1	2%	7	12%	1	2%	17	6%
Four	6	15%	1	2%			5	8%			12	4%
Five	2	5%			1	2%					3	1%
Column Total	40	100%	56	100%	56	100%	61	100%	62	100%	275	100%
Mean	2.02		1.41		1.21		1.75		.79		1.40	
Standard Deviation . .	1.39		.73		.80		1.01		.66		1.00	

TABLE 45

CMHC Client Status at Time Intensive Case Management Services Began and Services Received During the 3 Month Period Before Opening By Intensive Case Management Site

	Intensive Case Management Program Site																					
	Miles City		Glendive		Great Falls		Havre		Billings		Helena		Butte		Living-ston		Missoula		Kalis-pell		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
CMHC Client																						
Yes	26	87%	14	88%	44	62%	12	86%	56	73%	28	22%	20	80%	13	81%	40	36%	22	51%	275	70%
No	4	13%	2	12%	27	38%	2	14%	21	27%	4	78%	5	20%	3	19%	23	64%	21	49	116	30%
Column Total	30	100%	16	100%	71	100%	14	100%	77	100%	36	100%	25	100%	16	100%	63	100%	43	100%	391	100%
Service Received																						
Outpatient Individual .	20	77%	7	50%	26	60%	9	75%	22	39%	14	50%	6	30%	2	15%	7	18%	11	50%	124	45%
Outpatient Group	2	8%			1	2%	3	25%	3	5%	2	7%					1	2%			12	4%
Day Treatment	20	77%	10	71%	14	32%	10	84%	13	23%	25	90%	14	70%	10	77%	9	22%	6	27%	131	48%
Community Living Support	10	38%			11	25%			18	32%	17	61%			5	39%	13	32%			74	27%
Transitional Living . .	10	38%	1	7%					5	9%	7	25%	1	5%							24	9%
Inpatient	1	4%			2	4%	3	25%	6	11%	3	11%	1	5%			1	2%	1	4%	18	6%

TABLE 46

Number of Different Services Received During the
3 Months Prior to Intensive Case Management Services
For CMHC Clients By Intensive Case Management Site

	Intensive Case Management Program Site																					
	Miles City		Glendive		Great Falls		Havre		Billings		Helena		Butte		Living-ston		Missoula		Kalis-pell		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Number of Services																						
None	1	4%	2	14%	2	4%			6	11%			2	10%	1	8%	15	38%	5	23%	34	12%
One	9	35%	7	50%	31	70%	3	25%	36	64%	4	14%	15	75%	7	54%	20	50%	16	73%	148	54%
Two	4	15	4	29%	10	23%	6	50%	12	21%	13	46%	2	10%	5	38%	4	10%	1	4%	61	22%
Three	4	15	1	7%	1	2%	2	17%	1	2%	6	21%	1	5%			1	2%			17	6%
Four	6	23					1	8%			5	18%									12	4%
Five	2	8							1	2%											3	1%
Column Total	26	100%	14	100%	44	100%	12	100%	58	100%	28	100%	20	100%	13	100%	40	100%	22	100%	275	100%
Mean	2.42		1.29		1.23		2.08		1.21		2.43		1.10		1.31		.78		.81		1.40	
Standard Deviation . .	1.47		.83		.56		.90		.80		.96		.64		.63		.73		.50		1.00	